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Reprint from the St. Louis Courier of Medicine, August, 1883.

The Management of Abortion.

By Walter Coles, M. D.

[*Read before the St. Louis Obstetrical and Gynecological Society, April 19, 1883.*]

I FEEL that no apology is necessary in introducing the subject of the *management of abortion*. And in order that our discussion may not assume too wide a range, I propose to confine it to a consideration of the discharge or delivery of the secundines. *When* and *how* should the physician interfere with this process, are important practical questions, the solution of which, although they have been frequently answered, is by no means definitely settled, if we are to judge by the diverse views which have of late been promulgated on this subject.

It is the duty of every physician and surgeon to keep himself informed, as far as possible, on all important advancements in the special branches which he may practice, and he is certainly morally culpable if he neglects to avail

himself of every attainable improvement whereby he may give his patients the best advantages in his power.

In view of the advanced doctrines which have been recently published in certain quarters, wherein the "*immediate removal*" of the secundines is laid down as the inexorable rule of practice, it behooves those who are less heroically inclined to defend their position, lest our conduct become the subject of criticism. Whether such criticism be just or unjust would depend not so much upon what might be said of it, as on the intrinsic merits of the practice pursued. With the object of bringing out discussion on this point I propose to briefly compare the various plans recommended, in order, if possible, to arrive at an understanding as to the safest and best method of dealing with this, often perplexing and troublesome, class of cases.

In the *American Journal of Obstetrics*, Feb., 1883, Dr. Paul F. Mundé, of N. Y., has written an article entitled, "*The immediate removal of the secundines after abortion*," in approval of another paper in the same journal by Dr. Alloway, of Montreal. The title of Dr. Alloway's paper is "*The immediate use of the uterine scoop or curette in the treatment of abortions, vs. waiting, or the expectant plan.*" Dr. Mundé says: "Having now expressed my opinion that the future safety of the patient demands that the secundines should be *at once* removed after expulsion of the fetus in every case of abortion in which such removal can be accomplished without force sufficient to injure the woman, I will proceed to describe the manner in which it has been my custom to perform this operation." The doctor then goes on to say that when called to a case in which the fetus had already been expelled, he would proceed "*at once*" to "*forcibly*" deliver the secundines by manual or instrumental means, provided the cervix was sufficiently patulous to admit a finger or curette, the patient being chloroformed for the purpose, and, where contraction of the internal os exists to such an extent as to prevent this, he would immediately resort to forcible dilatation. As I understand

them, this would be the practice of Drs. Alloway and Mundé in all cases where there was reason to believe that any portion of the ovum or its appurtenances were still retained in utero, whether the immediate symptoms were urgent or otherwise; furthermore that they would follow this practice to the exclusion of what is ordinarily known as the *expectant plan.*

While it is far from my desire to detract from much that is meritorious in the two papers alluded to, candor impels me to say that the doctrines inculcated therein are somewhat ultra and dangerous in their tendencies, being too dogmatic and sweeping in character, while at the same time they are lacking in fairness towards those who hold more conservative views. Dr. Alloway commences his paper by remarking that "In recently published text-books on obstetrics, we find insufficient stress laid upon the importance of removing *at once* a retained placenta after abortion." Dr. Mundé, in endorsing the foregoing, places all who would not advise the immediate chloroforming of a woman and "*at once*" and "*forcibly*" removing a retained placenta, as in favor of a "*let-alone*" policy. Now this is by no means a fair statement of the attitude of our "*older confrères*," or of the less "*progressive*" among the younger members of the profession who are not *en rapport* with such advanced ideas. There is certainly a broad intermediate ground between a "*do-nothing*" and "*let-alone*" policy and the heroic measures recommend by Dr. Mundé.

Although the act of abortion is a pathological process, yet, like most other such processes it is more or less amenable to natural laws, which when properly guided and directed generally lead to a favorable termination. Under such circumstances nature often needs judicious assistance, but according to my experience it is seldom that her powers are so absolutely impotent as to require that they be unceremoniously ignored and supplanted by art.

To everyone of experience it must be apparent that no

routine treatment can be laid down for abortion. While certain fundamental principles must govern our action, our precise line of conduct will depend upon the circumstances surrounding each individual case. In a word, it is the attendant's duty to reduce bleeding to a minimum and see that the uterus is effectually emptied at the earliest practicable moment. The methods which he should adopt to attain these ends must of course vary according to the stage of pregnancy, the degree of hemorrhage, and the condition of the os. Sometimes in early spontaneous abortions the entire ovum with all its annexæ will have escaped before the physician arrives. In such cases, although the hemorrhage may have been serious, it will be found to have nearly or quite ceased, and there is left little or nothing to do. Not unfrequently, owing to carelessness in disposing of blood-clots, the attendant finds himself in doubt whether the abortion has been completed or not. Under such circumstances he must be guided by certain indications. If he finds that all pain has ceased; that hemorrhage, which before had been considerable, has all stopped; that the uterus has been reduced in size, that its os is soft and patulous, and with no indication of any substance presenting from within, he would be warranted in assuming that the uterus was empty. Nevertheless it would be safe to administer a full dose of ergot, and, if any doubt remain, it would be well to place a temporary tampon in the vagina before quitting the house. This would be all that the utmost prudence could require under such circumstances; the attendant would certainly not be justified in forcibly dilating the uterus and scooping its interior without first "waiting" for the development of some evidence of retained secundines.

But, let us suppose that we have been called to a case in which the embryo has just escaped during the third month and the secundines are retained. Under such circumstances there is generally considerable hemorrhage going on, and the first thing in order is to check it. Of course the most

effectual and desirable method of so doing is to empty the uterus and cause it to contract. A teaspoonful of fluid extract of ergot is administered, and the accoucheur at once examines the uterus. If it be practicable by digital manipulation, or the aid of forceps, to deliver the placenta, this is a fortunate circumstance which should be availed of on the spot. But if the os is too contracted to admit the finger, or even if patulous and the membranous placenta is so adherent as only to be detached in fragments, it is better not to disturb it for the time being, rather than resort to immediate and forcible extraction. We should, however, be equally far from pursuing a *passive* policy; the hemorrhage should be controlled by means of a tampon, aided by ergot, supplemented by a full dose of tinct. of opium—the latter being especially beneficial as a soothing stimulant after blood loss. A tampon ought always be applied with the aid of a speculum, that of Sims being the best. There is a great deal in the method of tamponing; it should be carefully packed over the os and around the cervix. The best material is old cotton muslin torn into strips; I prefer to put it in dry. Sponge is of very little service as a tampon; it absorbs the blood and permits it to flow through.

In most cases thus managed the physician will find on removal of the tampon twelve hours later that the secundines have either escaped entire, or else are presenting at the os, whence they may be readily removed by very slight manipulation. But in case this cannot be done without violence, it would be proper to wash out the vagina and again tampon, with the expectation that under the excitation of the plug and the continued influence of ergot the uterus will by its contractions detach and expel its contents. If at the end of twenty-four or thirty-six hours there is no indication of dilatation, it will be quite time enough to consider the propriety of artificial dilatation and extraction. If the internal os continues closed, it is pretty conclusive evidence that the placenta is still adherent and

hence not extensively decomposed. Lusk recognizes this condition of the internal os as a valuable indication—a fact pointed out by Hüter. He remarks that "When decomposition has once set in, the os internum will, as a rule, allow the finger to pass into the uterus." Such being the case, we have less reason for being in a hurry when the uterus is closed than if the inner os were lax and the discharges offensive; under the latter condition of things the practitioner should lose no time in emptying the uterus of all decomposing material, provided he can do so without inflicting too much violence on the organ itself.

All I am contending for is against extreme measures either way. Of course there are cases in which the medical attendant would be culpable if he did not resort to the methods advocated by Drs. Priestly, Alloway, Mundé and others. No doubt all of us have seen such cases, and that we have been called to patients where some such active policy had been too long neglected. The testimony which these gentlemen bear to the utility of the curette and forceps is valuable, but that scoop or curette should be resorted to *primarily*, before *giving nature any voice in so important an affair*, certainly savors of rash practice, fraught with unnecessary suffering and danger.

The advocates of immediate and forcible removal of the placenta are rather disposed to exaggerate the danger from hemorrhage. I would by no means underestimate the gravity of the serious depletion sometimes incident to abortion, but cases of fatal flooding must be exceedingly rare. In the majority of instances the most serious bleeding will be found to have already taken place before the physician reaches the patient; this usually commences prior to and during the extrusion of the embryo, to be greatly augmented immediately after this act and in the interval between it and the arrival of medical aid. I dare say this is the observation of all of us. Indeed, I may say that when a case of abortion is carefully watched from the start and properly managed with tampon, ergot and opium, it must

be exceptional for anything like a fatal or even dangerous hemorrhage to occur. At any rate the danger from this source is not sufficiently imminent to warrant immediate and vigorous measures for forcible extraction of the secundines when the chances are ten to one that nature when judiciously aided will accomplish the same end with much less hazard. For no matter how skillfully and cautiously done, a young, almost membranous placenta, when adherent and in a perfectly fresh state, cannot be detached without a certain degree of force, which materially aggravates the traumatism already existing and which is one of the chief and unavoidable dangers in every case of abortion.

We are assured by the advocates of immediate removal that this feat is very easy of accomplishment,—a thing which the merest tyro may perform—but most of our leading obstetrical authorities entertain a different view of the difficulties and dangers involved. Playfair, while admitting the desirability of emptying the uterus when feasible, goes on to say: "Cases, however, are frequently met with in which any forcible attempt at removal would be likely to prove very hurtful, and in which it is better practice to control hemorrhage by the plug or sponge tent and wait until the placenta is detached, which it will generally be in a day or two at most." Barnes reiterates the same advice, and cautions us that "We must not persevere too pertinaciously in the attempt at removal lest we inflict injury upon the uterus." The same author, recognizing the fact that the placenta, after abortion, quickly undergoes retrograde changes whereby its adherence to the uterine wall is weakened, thereby facilitating its removal, remarks that "The consulting practitioner here occasionally reaps credit which is scarcely his due. He is called in, perhaps, on the third day, or later, when the adhesion of the decidua to the uterus is breaking down. He passes in his fingers and extracts at once. But, had he tried the day before, he might have failed like the medical attendant in charge. (*Obstet. Operations*, p. 359.)

In this connection I trust I may be excused for again referring to the papers of Doctors Alloway and Mundé. Dr. Alloway publishes five cases which he "treated by *immediate removal* of the secundines with the curette," and yet, strange to say, but *one* of them is in any sense illustrative of the principle inculcated in his paper. For in one the placenta was removed on the third day; one on the seventh and eighth days respectively, while the fourth was simply the premature delivery of a syphilitic child in the sixth month, and of course he delivered the after-birth, as is usual in obstetric practice. Dr. Mundé's table, in which he gives the result of fifty-seven cases in his own hands, is open to similar criticism. It certainly does not illustrate the "*immediate*" delivery of the secundines, as in thirty-nine, or upwards of sixty-eight per cent. of his cases, they were delivered after the lapse of from twenty-four hours to sixty days. Indeed, so far as delivery "*at once*" with the curette is concerned, we look in vain for a single typical example—there being but four instances in which this instrument was employed under eighteen hours, and even in these only after the lapse of "several hours." In nearly all the cases where Dr. Mund resorted to the curette, the instrument was clearly indicated to dislodge putrid masses after the lapse of several days or weeks; and the fact that they terminated so favorably would indicate that there is less danger in temporary retention than is generally supposed, and furthermore, that as a *secondary measure of relief*, the curette is a valuable resource, as has been long since pointed out by Matthews Duncan and others. To this extent Dr. Mundé's statistics are interesting, though it would seem that they contain no data sufficient to warrant any decidedly new departure in practice, or as bearing on the special points advanced in his paper.

Whenever the uterus can expel the placenta within a reasonable time, that is to say, before decomposition takes place, it is better to rely on nature than on mechanical force, for the reason that uterine contraction nearly always

effects a more perfect separation and cleaner deliverance. This is also much more apt to occur if the secundines are not interfered with, and are allowed to come away *en masse*. It is always a misfortune, to be guarded against if possible, when the placenta is broken into fragments, for we can then never be quite sure that we have gotten it all, while the consequent diminution in bulk renders the uterus less able to expel any remaining portions, which may tend in future to provoke continued bleeding, or septicemia, two of the evils sought to be avoided.

Whenever there is serious and persistent hemorrhage threatening to exhaust the patient, active interference is of course demanded. Or, if there is an offensive discharge, and an elevated temperature together with rigors, we have good reasons to apprehend blood-poisoning from the absorption of putrefying elements within the uterus. Under such circumstances it would be proper to explore the interior of this organ, dilatation being resorted to if necessary. For this purpose the tupelo tent is certainly far superior to the sponge or sea-tangle. It has all the dilating qualities of sponge, while it is cleaner and can be introduced more readily, even without a speculum if desired. It has also the advantage over the sea-tangle in that it can be procured in larger sizes and is less liable to slip out of position. Whenever full dilatation is required the tupelo is preferable to all other tents. The uterine cavity having been exposed, all fragments of secundines should be carefully dislodged with either the finger or curette, after the manner so well described by Lusk and Mundé, and the organ washed out with some disinfectant fluid. Where there is a tendency to bleeding, tincture of iodine answers an excellent purpose, and is cleaner than perchloride or persulphate or iron as recommended by Barnes. Where the disintegrating fragments are small, repeated irrigation of the uterine cavity (the os being patulous) will generally suffice, as they usually melt down and come away with the discharges. It is not safe to scrape the uterine surface more

than can be avoided, for fear of opening up fresh avenues by which septic materials may reach the system, since we know that nature interposes a bar to infection by glazing over denuded surfaces and closing gaping vessels. For this reason Lusk remarks that "Fatal results are, however, rare, as decomposition is usually a late occurrence, setting in, as a rule, only after protective granulations have formed upon the uterine mucous membrane and after the complete closure of the uterine sinuses. (*Science and Art of Midwifery*, p. 297.)

In 1875 I contributed several articles to the *St. Louis Medical and Surgical Journal* on the subject of "*Abortion, its Causes and Treatment.*" The following is the concluding paragraph of my last paper on that subject: "In all cases of abortion when there is is a prompt and clean delivery, but little trouble is to be apprehended. Matters do not always progress thus favorably however, and the practitioner frequently finds himself confronted with one or more of four complications, for which he should always be on the alert: these are *imperfect deliverance*, *hemorrhage*, *septicemia* and *inflammation*. Now these conditions nearly always bear a certain reciprocal relation to each other, as well cause and effect, as in point of absolute danger. What are these relations; what their comparative danger? The proper answer to these queries embodies the practical management of abortion. The dilemma may be thus stated: If there is imperfect deliverance we are almost sure to have hemorrhage, whilst if in order to staunch the latter, we use heroic means to obviate the former, inflammation may be provoked; on the other hand if these measures are neglected, there is risk of septicemia. The whole question therefore turns upon the comparative importance inherent in each one of these conditions. The writer is clearly of the opinion that of all these complications *inflammation* is the one most to be dreaded; and for the reason that women *rarely flood to death* during abortion, while *many die from inflammation*, the result of rough manipulation of the

uterus. Not only is this so, but inflammation under such circumstances is peculiarly liable to septic complications; indeed it is quite certain that the breaking up and gouging out of the placenta, by which the mucous membrane is bruised and lacerated, predisposes more certainly to septic fever than the temporary retention of the secundines would be likely to do. Even with the greatest care it is frequently impossible to remove the after-birth without breaking and leaving more or less behind as the focus of fresh hemorrhage, irritation and poison; whereas if left to nature for a few hours, or even days, easy detachment might be effected, great peril avoided, and perhaps a life saved. The good old maxim, 'meddlesome midwifery is bad,' applies as well to the management of abortion as to labor at term, and *unless there are clear indications for it*, of which every man must judge for himself, we hold that it is better to pursue an expectant policy in reference to the placenta, believing that upon the whole the risk is less when nature has at least some voice in its detachment and delivery, than when it is precipitated by unnecessary interference."

Such, Mr. President, was my conclusion eight years ago, and experience and observation during the interval but confirms this belief. Undoubtedly the chief peril of the aborting woman is *inflammation*, whether the result be death or the well-known train of aches and ills which follow in its wake. The moral of which is that we should treat the uterus under such circumstances with as little violence as possible.

ST. LOUIS COURIER OF MEDICINE,

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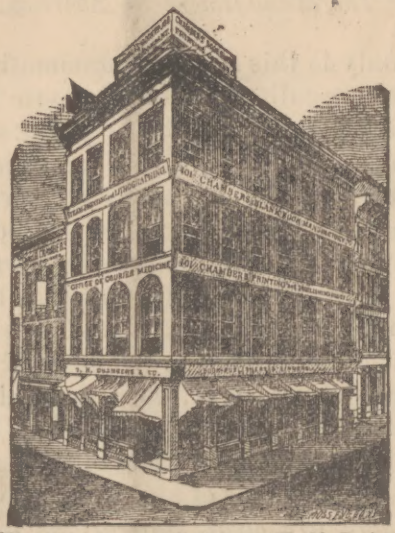

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